DRUG PRIOR AUTHORIZATION REQUEST
CONFIDENTIAL PATIENT INFORMATION
San Diego LIHP Program

Fax to: 866-511-2202
Customer Service Help Desk: (800) 777-0074

If this is an URGENT REQUEST check here: ☐ Fax to the 'Urgent Fax Line' at 877-636-9001

Note: This FAX line MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. iRx Clinical Pharmacists reserve judgment of urgency and must meet definition above, therefore, please explain reason for urgency below. This fax line is monitored for abuse.

Top portion and medication request information to be completed by physician requesting prior authorization.

Name of Member's Health Plan: **County of San Diego Low Income Health Program**
Date of Request:
Physician:
MD office Contact Person Name and Signature:
Physician's Fax Number:
Physician's Phone Number:
Physician's Specialty:
Pharmacy Name:
Pharmacy Fax Number: ( )
Pharmacy Contact:
Pharmacy Phone Number: ( )

Patient's Last Name, First Name **Patient's ID#**

Sex: Male Female **Patient's DOB**

Patient's Phone Number

MEDICATION REQUEST: ☐ NEW ☐ RENEWAL RENEWAL/ORIGINAL RX Date:_____

DIAGNOSIS (LIST RELEVANT):

CURRENT MEDICATION(S):

FORMULARY DRUGS TRIED AND MEDICAL JUSTIFICATION:

DRUG and STRENGTH:_____NDC:_____
DIRECTIONS:_____MONTHLY QTY:_____#REFILLS:_____

FOR Informed Rx USE ONLY

☐ Approved ☐ Denied ☐ Deferred for Additional Information ☐ Approved As Modified ☐ Pt. Not Eligible

COMMENTS:

_____

Authorizing Signature _____ **Date**_____